

<i>SERFF Tracking Number:</i>	<i>CAIC-125785270</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Boston Mutual Life Ins Co</i>	<i>State Tracking Number:</i>	<i>40021</i>
<i>Company Tracking Number:</i>	<i>5093</i>		
<i>TOI:</i>	<i>H07G Group Health - Specified Disease - Limited Benefit</i>	<i>Sub-TOI:</i>	<i>H07G.001 Critical Illness</i>
<i>Product Name:</i>	<i>AR BM Critical Illness</i>		
<i>Project Name/Number:</i>	<i>AR BM Critical Illness/5093</i>		

Filing at a Glance

Company: Boston Mutual Life Ins Co	SERFF Tr Num: CAIC-125785270	State: ArkansasLH
Product Name: AR BM Critical Illness	SERFF Status: Closed	State Tr Num: 40021
TOI: H07G Group Health - Specified Disease - Limited Benefit		
Sub-TOI: H07G.001 Critical Illness	Co Tr Num: 5093	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Cindy Lama	Disposition Date: 08/27/2008
	Date Submitted: 08/21/2008	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:
State Filing Description:		

General Information

Project Name: AR BM Critical Illness	Status of Filing in Domicile: Authorized
Project Number: 5093	Date Approved in Domicile: 04/24/2007
Requested Filing Mode: Informational	Domicile Status Comments: Approved in Boston Mutual Life Ins. Co.'s Domicile: MA 4/24/2007.
	Approved in Rhode Island Trust 11/20/2007.
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Employer, Trust
Filing Status Changed: 08/27/2008	
State Status Changed: 08/27/2008	Deemer Date:
Corresponding Filing Tracking Number: 5093	
Filing Description:	
Re: BOSTON MUTUAL LIFE INSURANCE COMPANY	
NAIC: 61476 Group # 0581 FEIN 04-1106240	

SERFF Tracking Number: CAIC-125785270 *State:* Arkansas
Filing Company: Boston Mutual Life Ins Co *State Tracking Number:* 40021
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BMT2100-MP Master Policy
BMT2100-CI Certificate
BMT2100-DCR RI Dependent Rider
BMTCIADL Activities of Daily Living/Skilled Nursing Rider
BMSW Strike Waiver
BM-2006-CI Enrollment Application
BM-CI-707 STD Enrollment Application
BM-CI-SPS-GI-707 Enrollment Application

The above captioned forms are being filed for informational purposes only. These forms will be issued through an out of state trust, sitused in Rhode Island. The forms were approved in the state of Rhode Island on 11/20/2007.

The forms contained in this filing represents Boston Mutual Life's Critical Illness Insurance which offers lump sum benefits to covered individuals upon diagnosis of a covered critical illness. This Plan of insurance will be marketed by Boston Mutual Life Insurance Company to employees of an employer on a voluntary, payroll deduction basis. This policy offers coverage to employees and their dependants.

Boston Mutual Life Insurance Company has retained Continental American Insurance Company to submit this filing on their behalf. A letter of authorization from Boston Mutual is enclosed.

Thank you for your consideration in this matter. Please contact Cindy Lama at 888-730-2244, ext: 4333 or at CompanyCompliance@caicworksite.com if you need any additional information.

Sincerely,

James J. Hennessy, AIRC, ACP, CCP
Authorized Consultant
Vice President, CAIC

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Company and Contact

Filing Contact Information

Cindy Lama, Compliance Analyst
 2801 Devine Street
 Columbia, SC 29205

companycompliance@caicworksite.com
 (888) 730-2244 [Phone]
 (803) 929-4992[FAX]

Filing Company Information

Boston Mutual Life Ins Co
 2801 Devine Street
 Columbia, SC 29205

CoCode: 61476 State of Domicile: Massachusetts
 Group Code: Company Type: LAH
 Group Name: Boston Mutual Life State ID Number:
 Ins Co
 FEIN Number: 04-1106240

(803) 256-6265 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$0.00
 Retaliatory? No
 Fee Explanation: We called ARDOI and they told us there are no filing fees for informational filings.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Boston Mutual Life Ins Co	\$0.00	08/21/2008	

SERFF Tracking Number:	CAIC-125785270	State:	Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/27/2008	08/27/2008

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Disposition

Disposition Date: 08/27/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: CAIC-125785270 State: Arkansas

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Cover Letter & Authorization Letter	Approved-Closed	Yes
Form	Master Policy	Approved-Closed	Yes
Form	Certificate	Approved-Closed	Yes
Form	Dependent Rider	Approved-Closed	Yes
Form	Activities of Daily Living/Skilled Nursing Rider	Approved-Closed	Yes
Form	Strike Waiver	Approved-Closed	Yes
Form	Enrollment Application	Approved-Closed	Yes
Form	Enrollment Application	Approved-Closed	Yes
Form	Enrollment Application	Approved-Closed	Yes

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Form Schedule

Lead Form Number: BMT2100-MP

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	BMT2100-MP	Policy/Cont ract/Fraternal Certificate	Master Policy	Initial		46	BMT2100-MP.pdf
Approved-Closed	BMT2100-CI	Certificate	Certificate	Initial		44	BMT2100-CI.pdf
Approved-Closed	BMT2100-DCR RI	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Dependent Rider	Initial		42	BMT2100-DCR RI.pdf
Approved-Closed	BMTCIADL	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Activities of Daily Living/Skilled Nursing Rider	Initial		43	BMTCIADL.pdf
Approved-Closed	BMSW	Certificate	Strike Waiver	Initial		57	BMSW.pdf
Approved-Closed	BM-2006-CI	Application/ Enrollment Form	Enrollment Application	Initial		44	BM-2006-CI.pdf
Approved-Closed	BM-CI-707 STD	Application/ Enrollment Form	Enrollment Application	Initial		45	BM-CI-707 STD.pdf
Approved-Closed	BM-CI-SPS-GI-707 STD	Application/ Enrollment Form	Enrollment Application	Initial		45	BM-CI-SPS-GI-707.pdf



120 ROYALL STREET ♦ CANTON, MASSACHUSETTS 02021 ♦ TEL. (800) 669-2668 ♦ FAX (781) 770-0521

GROUP CRITICAL ILLNESS POLICY

[Boston Mutual Life Insurance Trust]
(herein called the Participant)

Based on the application of the Trustee and the payment of the premium when due by each Participating Employer (herein called Participants) the Company agrees to pay the benefits provided in this Policy (herein called the Plan).

**THIS IS A LIMITED POLICY. PLEASE READ IT CAREFULLY
THIS POLICY PROVIDES BENEFITS FOR THE SPECIFIED DISEASES LISTED.
IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.**

This Plan becomes effective at 12:01 a.m. Standard Time at the Policyholder's address on the Effective Date shown below. It may be continued in effect by the payment of premiums as provided in Section II. The Plan will terminate as provided in the provision titled "Termination of the Plan" in Section I.

The first anniversary of this Plan will be the Anniversary Date shown below. "You" and "your" refer to the Insured or any other Insured under Family Coverage. "We", "us", and "our" refer to the Company. The Participant may add new Employees or Dependents from time to time in accordance with the terms of the Plan. Subsequent anniversaries of the Plan will be the same date each year thereafter.

All matter printed or written by the Company on the following pages forms a part of this Plan as if recited over the signatures below. This Plan is a legal contract between the Company and the Policyholder. This Plan is delivered in and is governed by the laws of the jurisdiction shown below.

In witness whereof the Company has caused this Plan to be executed at our Home Office in Boston, Massachusetts on the Effective Date.

READ YOUR POLICY CAREFULLY.
Signed for the Company at our Home Office.

Secretary

President

Countersigned by _____
Licensed Resident Agent (if required by your state)

Group Policy Number -	[1234]	
Effective Date -	[May 1, 2007]	Anniversary Date - [May 1, 2008]
Jurisdiction -	Rhode Island	Non-Participating

GROUP POLICY PROVISIONS

SECTION I	-	Eligibility, Effective Date and Termination
SECTION II	-	Premium Provisions
SECTION III	-	General Definitions / Benefit Definitions
SECTION IV	-	Benefit Provisions
SECTION V	-	Limitations and Exclusions
SECTION VI	-	Claim Provisions
SECTION VII	-	General Provisions
SECTION VIII	-	Benefit Schedules
SECTION IX	-	Occupational Classifications
SECTION X	-	Schedule of Premiums

SECTION I - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

ELIGIBILITY

Employee as used in this Plan, means a person insured under this Plan who is:

1. an Employee of the Participant, or an eligible Spouse of the Employee;
2. under age 70; and
3. engaged in full-time work; and
4. included in the class of employees eligible for coverage as shown on the application.

EFFECTIVE DATE

The Effective Date of this Plan is shown on Page 1 of this Policy.

The Effective Date for an Employee is as follows:

1. An Employee's insurance will be effective on the date shown on the Certificate Schedule provided the Employee is then actively at work.
2. If an Employee is not actively at work on the date coverage would otherwise become effective, the Effective Date of his coverage will be the date on which such Employee is first thereafter actively at work.

The Effective Date for a Spouse or Dependent Child is the date shown on the Schedule Page subject to the following:

1. The date the Employees insurance is effective for a spouse or Dependent Child who is eligible on that date; for whom coverage is applied for and premium paid; and who are not hospital confined.
2. At 12:00 a.m. Standard Time, on the day a spouse or Dependent Child is no longer hospital confined if the spouse or Dependent Child was otherwise eligible for coverage on the date the Employee's insurance became effective.
3. For a spouse or Dependent Child eligible on or first acquired after the Employee's Effective Date, the Effective Date will be:
 - a. For newborn children, the Effective Date is the moment of birth, but we must be given notice of the birth within 31 days for coverage to continue beyond 31 days (see Section III, Definitions, Insured).
 - b. For other than newborn children, the date we assign after approving the application for such coverage.

TERMINATION OF THE PLAN

The Plan will cease if the premium is not paid before the end of the Grace Period.

After the end of the first Plan year, the Company has the right to cancel the Participant's participation in the Plan on the day prior to the date any premium is due by giving 31 days written notice. Coverage under this Plan will terminate when the number of participating Employees is less than the number mutually agreed upon by a Participant and the Company in writing.

In these events, a Participant's participation and all certificates issued to his employees hereunder will terminate on such date at 12:01 a.m. Standard Time at the Participant's address. This will be without prejudice to the rights of any Insured as respects any claim arising during the period his certificate was in force.

The Participant has the sole responsibility to notify Employees of such termination.

TERMINATION OF AN EMPLOYEE'S INSURANCE

An Employee's insurance will terminate on the earliest of:

1. the date the Plan is terminated;
2. the date his employer is no longer a Participant;
3. on the 31st day after the premium due date if the required premium has not been paid;
4. on the date he ceases to meet the definition of an Employee as defined in the Plan; or
5. on the date he is no longer a member of the class eligible.

Insurance for an insured spouse or Dependent Child will terminate the earliest of:

1. the date the Plan is terminated;
2. the date the Employee is no longer insured under this Plan;
3. on the 31st day after the premium due date if the required premium has not been paid;
4. the premium due date following the date the spouse or child ceases to be a dependent;
5. the premium due date following the date we receive your written request to terminate coverage for your spouse and/or all Dependent Children.

Termination of the insurance on any Insured shall be without prejudice to his rights as regarding any claim arising prior thereto.

SECTION II - PREMIUM PROVISIONS

PREMIUM CALCULATIONS

Premiums payable on any premium due date for insurance will be calculated in accordance with the Schedule of Premiums. The rates shown in this Schedule can be changed annually. The Company will give the Participant written notice 31 days prior to the date any change in rates is to be effective.

PREMIUM PAYMENTS

The first premiums are due on the Effective Date of this Plan. After that, premiums are due on the first day of each month that the Plan remains in effect.

Aggregate premiums for this Plan are to be paid to the Company at our Home Office in Boston, Massachusetts. Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period.

GRACE PERIOD

This Plan has a 31-day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the next 31 days. During the Grace Period, the Plan will stay in force, unless the Participant has given the Company written notice of discontinuance of his participation in the Plan.

SECTION III - GENERAL DEFINITIONS / BENEFIT DEFINITIONS

Whenever a male pronoun is used, it includes the female unless the context clearly shows otherwise.

Insured(s) -

1. If Employee coverage is shown in the Certificate Schedule, we insure the Employee.

2. If coverage is for the Spouse of an eligible Employee, we insure the Insured as shown on the Certificate Schedule.
3. Coverage for Dependent Children may be included in an attached rider (if applicable). Coverage for Dependent Children is subject to the following:
 - a. Newborn children of an employee and/or their Spouse shall automatically be covered from birth provided that we receive notification within thirty-one (31) days after the birth of the child. Foster children shall be eligible for coverage on the same basis upon placement in the foster home.
 - b. Children for which a decree of adoption has been entered by the Employee and/or their spouse (or for whom adoption proceedings have been instituted by the employee and/or their spouse), shall be covered automatically from birth. A decree of adoption must be entered within one year from the date proceedings were instituted, unless extended by order of the court, and the Employee and/or their spouse must continue to have custody pursuant to the decree of the court.
4. If any person who would otherwise be an Insured is specifically excluded from coverage by endorsement to the Certificate or by the application, then such person shall not be an Insured.
5. Any other additions to the Insured class must be added by endorsement after applying to the Company.

Successor Insured - If an Employee dies while covered under a Certificate, then their surviving spouse shall become the Insured if such spouse is an Insured. If there is no surviving spouse covered under the Certificate, then the Certificate shall terminate on the next premium due date.

Dependent Child(ren) - All of an Employee's children who are unmarried and less than twenty-five (25) years of age. However, if any Dependent Child is incapable of self-sustaining employment due to mental retardation or physical handicap and is dependent on a parent(s) for support, such age of twenty-five (25) shall not apply. Proof of such incapacity and dependency must be furnished to the Company within thirty-one (31) days following such 25th birthday.

Pathologist means a doctor, other than an Insured or a family member, who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A Pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Doctor or Physician means any licensed practitioner of the healing arts acting within the scope of his license in treating an injury or illness. It doesn't include an Insured or their family member.

Family Member means an Insured's spouse, son, daughter, mother, father, sister, or brother.

Illness means sickness or disease which first manifests while the Insured's coverage is in force and after any applicable Waiting Period. Any loss due to illness must begin while the Insured's coverage is in force.

Injury means bodily injury solely due to an accident. It includes all complications of and all injuries from the same accident. The accident must occur and any loss due to injury must begin while the Insured's coverage is in force and after any applicable Waiting Period.

Actively at Work to be considered "actively at work", the Employee must perform for a full normal workday the regular duties of his employment at the regular place of business the Participant or at a location to which he may be required to travel to perform the regular duties of his employment.

Full-time Work means spending at least [30] hours per week performing your occupational duties.

Employee means the Insured as shown in the Certificate Schedule.

Treatment means consultation, care or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.

Specified Critical Illness means such illness shown in the Schedule and as defined in this Plan.

Waiting Period means the number of days after the Effective Date before we will pay benefits for loss due to a Specified Critical Illness. We won't pay benefits for a Specified Critical Illness that begins during the Waiting Period.

Date of Diagnosis The date of diagnosis is:

[**For cancer and/or carcinoma in situ:** The day the tissue specimen, blood samples and/or titer(s) are taken on which the first diagnosis of cancer or carcinoma in situ is based.]

For heart attack: The date that the death (infarction) of a portion of the heart muscle occurred based on the criteria listed under the Heart Attack definition.

For stroke: The date a stroke occurred based on documented neurological deficits and neuroimaging studies.

For end stage renal failure: The date that a doctor or physician recommends that an Insured begin renal dialysis.

Major organ transplant surgery or coronary artery bypass surgery: The date the surgery occurs for covered transplants or covered coronary artery bypass surgery.

BENEFIT DEFINITIONS

[**Cancer** means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of distant tissue. Cancer includes Leukemia. Excluded are Cancers such as:

1. Pre-malignant tumors or polyps;
2. Carcinoma in Situ (non-invasion);
3. Any skin cancers except melanomas;
4. Stage 1 Hodgkin's Disease and Stage A Prostate Cancer;
5. Basal cell carcinoma and squamous cell carcinoma of the skin; and
6. Melanoma that is diagnosed as Clark's Level I or II or Breslow less than .77mm.

Cancer is also defined as Cancer which meets the diagnosis criteria of malignancy established by The American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen.

Carcinoma in Situ means Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

Cancer and/or Carcinoma in Situ must be diagnosed in one of two ways:

1. **Pathological Diagnosis** - A Pathological Diagnosis of Cancer or Carcinoma in Situ is based on a

microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a Certified Pathologist whose diagnosis of malignancy is in keeping with the standards set up by the American Board of Pathology.

2. **Clinical Diagnosis** - A Clinical Diagnosis of Cancer or Carcinoma in Situ is based on the study of symptoms.

We will pay benefits for a Clinical Diagnosis only if:

- a. a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening; and
- b. there is medical evidence to support the diagnosis; and
- c. a doctor is treating an Insured for Cancer and/or Carcinoma in Situ.]

Myocardial Infarction (Heart Attack) means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart Attack does not include any other disease or injury involving the cardiovascular system. Cardiac Arrest not caused by a Myocardial Infarction is not a Heart Attack. The diagnosis must include all of the following criteria:

1. New and serial Electrocardiographic (EKG) findings consistent with Myocardial Infarction;
2. Elevation of cardiac enzymes above generally accepted laboratory levels of normal in case of creatine phosphokinase (CPK), a CPK-MB measurement must be used;
3. Confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms; and
4. Chest Pain.

Coronary Artery Bypass Surgery means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding procedures such as, but not limited to balloon angioplasty, laser relief, stents or other non-surgical procedures.

Major Organ Transplant means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas.

Stroke means apoplexy (due to rupture or acute occlusion of a cerebral artery), or a cerebral vascular accident or incident, which is first manifested on or after the Effective Date. Stroke does not include Transient Ischemic Attacks and attacks of Vertebrobasilar Ischemia. We will pay a benefit for Stroke which produces permanent clinical neurological sequela following an initial diagnosis made after any applicable Waiting Period. We must receive evidence of the permanent neurological damage provided from Computed Axial Tomography (CAT scan) or magnetic Resonance Imaging (MRI). **Stroke does not mean head injury, transient ischemic attack or chronic cerebrovascular insufficiency.**

Renal Failure (Kidney Failure) means the end stage renal failure presenting as chronic, irreversible failure of both of kidneys to function. The Kidney Failure must necessitate regular renal dialysis, hemo-dialysis or peritoneal dialysis (at least weekly); or which results in kidney transplantation. Renal failure is covered, provided it is not caused by a traumatic event, including surgical traumas.

SECTION IV - BENEFITS

Specified Critical Illness Benefit

We will pay this benefit if an Insured is diagnosed with one of the Specified Critical Illnesses shown on the Certificate Schedule if:

1. The date of diagnosis is after the Waiting Period;

2. The date of diagnosis is while the Certificate and is in force; and
3. It is not excluded by name or specific description in the Certificate.

If the date of diagnosis of a Specified Critical Illness occurs during the Waiting Period, the Certificate may be returned for a full refund of premium.

The Certificate's Initial Maximum Benefit amount is shown in the Schedule. If the Schedule shows a Maximum Benefit Reduction Date, a Certificate's Maximum Benefit will be reduced to the Reduced Maximum Benefit Amount, also shown in the Schedule, on that date. Benefits will be based on the Maximum Benefit amount in effect when the loss begins. Any partial benefits paid will be deducted from the appropriate Specified Critical Illness.

Payment of benefits is subject to the following:

1. We will pay benefits for a Specified Critical Illness in the order the events occur.
2. No benefits are payable for each Specified Critical Illness after the first unless its date of diagnosis is separated from the prior Specified Critical Illness by at least 6 months.
3. Once benefits have been paid for a Specified Critical Illness, no additional benefits are payable for that same Specified Critical Illness unless the dates of diagnosis are separated by at least 12 months (12 months treatment free for cancer).

[Portability Privilege

When coverage would otherwise terminate under this Plan because an Employee ends employment with the Participant, they may elect to continue coverage. An Employee must have been continuously insured for at least six months under this Plan and/or the prior Plan just before the date their employment terminated. The coverage that may be continued is that which the Employee had on the date their employment terminated, including Dependent coverage then in effect.

1. Coverage may not be continued for any of the following reasons:
 - a. the Employee failed to pay any required premium;
 - b. the Employee attained age 70;
 - c. this Plan terminates.
2. To keep the Certificate in force the Employee must:
 - a. make written Application to the Company within 31 days after the date their insurance would otherwise terminate;
 - b. pay the required premium to the Company no later than 31 days after the date the Certificate would otherwise terminate; and
3. Insurance will cease on the earliest of these dates:
 - a. the date the Employee fails to pay any required premium;
 - b. the date this Plan is terminated.

If an Employee qualifies for this Portability Privilege as described, then the same Benefits, Plan Provisions, and Premium Rate as shown in their Certificate as previously issued will apply.]

[Health Screening Benefit (Calendar Year Limit)

We will pay this Benefit for the following Health Screening Tests performed after the Waiting Period and while

this Plan is in force. We will pay the amount shown in the Certificate Schedule for the following Health Screening Tests. This Benefit is payable once per calendar year up to the Maximum Benefit amount shown in the Certificate Schedule. Payment of this benefit will not reduce the face amount of the Certificate.

Health Screening Test is defined as:

1. Stress test on a bicycle or treadmill,
2. Fasting blood glucose test,
3. Blood test for triglycerides,
4. Serum cholesterol test to determine level of HDL and LDL,
5. Bone marrow testing,
6. Breast ultrasound,
7. CA 15-3 (blood test for breast cancer),
8. CA 125 (blood test for ovarian cancer),
9. CEA (blood test for colon cancer),
10. Chest X-ray,
11. Colonoscopy,
12. Flexible sigmoidoscopy,
13. Hemocult stool analysis,
14. Mammography,
15. Pap smear,
16. PSA (blood test for prostate cancer),
17. Serum Protein Electrophoresis (blood test for myeloma),
18. Thermography.

There is no limit to the number of years an Insured can receive benefits for Health Screening Tests, as long as this Plan is in force.

We will pay this benefit regardless of the results of the test.]

SECTION V - LIMITATIONS AND EXCLUSIONS

This Plan contains a 30-day "Waiting Period". This means no benefits are payable for any Insured who has been diagnosed before their coverage has been in force 30 days from their Effective Date. If an Insured is first diagnosed during the "Waiting Period", benefits for treatment of that Specified Critical Illness will apply only to loss commencing after 12 months from their Effective Date; or, at the Employee's option, they may elect to void the Certificate from the beginning and receive a full refund of premium.

PRE-EXISTING CONDITIONS LIMITATION

"Pre-existing Condition" means a sickness or physical condition which, within the 12-month period prior to an Insured's Effective Date resulted in the Insured receiving medical advice or treatment.

We will not pay benefits for any condition or illness starting within 12 months of an Insured's Effective Date which is caused by, contributed to, or resulting from a Pre-existing Condition.

A claim for benefits for loss starting after 12 months from an Insured's Effective Date will not be reduced or denied on the grounds that it is caused by a Pre-existing Condition.

A condition will no longer be considered Pre-existing at the end of 12 consecutive months starting and ending after an Insured's Effective Date.

EXCLUSIONS

We won't pay for loss due to:

1. Intentionally self inflicted injury or action.
2. Suicide or attempted suicide while sane or insane.
3. Illegal activities or participation in an illegal occupation.
4. War -declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence.
5. Substance Abuse.

SECTION VI - CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within sixty (60) days after a covered loss starts, or as soon as reasonably possible. The notice can be given to the Company at our Administrative Office at P.O. Box 1807 Columbia, South Carolina 29202. Notice should include the name of the Insured and the Certificate number.

Claim Forms: When we receive a notice of claim, we will send the Claimant forms for filing proof of loss. If the forms are not given within 15 working days, proof of loss requirements can be met by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss Section.

Proof of Loss: Written Proof of Loss must be furnished to the Company at our Administrative Office at P.O. Box 1807 Columbia, South Carolina 29202 within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than one year from the time proof is otherwise required.

Notice Of Our Claim Decisions - We will send you written notice of our claim decision within 30 days after we receive due proof of your loss. If there are special circumstances that require more time (such as the need to hold a hearing), we will send you a written notice within this timeframe that an additional 30 days is needed. If more time is still needed to make a claim determination, we will send you written notice during this initial 30 day extension stating the special circumstances that require an additional 30 days. You will have 45 days to provide any additional information requested.

If your claim is urgent, we will notify you of our decision within 72 hours. If we need more information, we will let you know within 24 hours of your claim. At that time we will tell you what additional information is needed to process your claim. You will have 48 hours to provide any additional information requested. We will notify you of our decision within 48 hours after we receive the requested information. Our response to an urgent care claim may be oral; if it is, we will confirm our decision in writing.

We will treat your claim as urgent if a delay in processing your claim could seriously jeopardize your life, health, or ability to regain maximum function, or if in the opinion of the treating physician, a delay would subject you to severe pain that cannot be managed without the care or treatment that is the subject of your claim.

If the claim is wholly or partly denied, our notice will include:

1. Reasons for such denial;
2. Reference to specific policy provisions, rules or guidelines on which the denial was based;
3. A description of the additional information needed to support your claim;
4. Information concerning your right to request that we review our decision; and
5. A description of our review procedures, time limits and notice of your right to bring civil action.

Review Of Denied Claims - For non-urgent claims this request must be in writing and must be received by us no more than 180 days after you receive notice of our claim decision. A request for a review of an urgent claim may be made over the phone. As part of this review, you may:

1. Send us written comments;
2. Review any non-privileged information relating to your claim; or
3. Provide us with other information or proof in support of your claim.

We will review your claim promptly after receiving your request. We will advise you of the results of our review within 60 days after we receive your request, or within 120 days if there are special circumstances that require more time (such as the need to hold a hearing). Our decision will be in writing and will include reference to specific policy provisions, rules or guidelines on which the decision was based, and notice of your right to bring a civil action.

If your appeal arises from our denial of an urgent claim, we will consider your appeal and notify you of our decision within 72 hours.

Time of Payment of Claims: Benefits payable under this Plan will be paid immediately upon receipt of acceptable Proof of Loss.

Payment of Claims: All benefits will be payable to the employee unless assigned by them or by operation of law. Any accrued benefit unpaid at the Insured's death may be paid to their estate.

Conformity with State Statutes: Any provision of this Plan which, on its Effective Date, is in conflict with the statutes of the state in which it was issued is hereby amended to conform to the minimum requirements of such statutes.

Additional Coverage with the Company: We will only pay benefits for covered Specified Critical Illness under one Specified Critical Illness Certificate if an Insured is covered by more than one of our Specified Critical Illness Certificates. An Insured may choose which Certificate they wish to keep in force by sending us written notice of their choice. We will return the premiums paid for any of our other Specified Critical Illness Certificates during the period there was more than one Certificate in force.

SECTION VII - GENERAL PROVISIONS

Questions or Comments: We want to hear from you. If you have any questions about this Plan, its benefits, the filing of claims, a complaint or a compliment, please call us at the toll free number listed (or write to us) on the front of this Plan. Thank you for your loyal patronage.

Entire Contract, Changes: This Policy together with the application, endorsements, benefit agreements, certificates and riders, if any, is the Entire Contract of Insurance. No change in this Plan shall be valid until approved in writing by an Executive Officer of the Company. Any change must be noted on or attached hereto. No agent may change this Plan or waive any of its Provisions. Any Rider, Endorsement or Application that modifies, limits or excludes coverage under this Plan must be signed by the Employee to be valid.

Physical Examination and Autopsy: We, at our expense, have the right to have an Insured examined as often as reasonable necessary while a claim is pending. In the case of death, we may also have any autopsy done unless prohibited by law.

Legal Action: No legal action may be brought to recover on this Plan within 60 days after written Proof of Loss has been given as required by this Plan. No such action may be brought after 3 years from the time written Proof of Loss is required to be given.

Time Limit on Certain Defenses: (1) After two years from an Insured's effective date of coverage, no misstatements, except fraudulent misstatements, made by the applicant in the application shall be used to void the coverage or to deny a claim for loss incurred commencing after the expiration of such two-year period (2) No claim for loss incurred commencing after two years from an Insured's Effective Date of coverage shall be reduced or denied on the grounds that a disease or physical condition, not excluded from coverage by name or specific description, had existed prior to such Effective Date.

Clerical Error: Clerical error by the Participant will not end coverage or continue terminated coverage. In the event of such clerical error, a premium adjustment will be made.

Misstatement of Age: If an age has been misstated on the application, the benefits will be those the premium paid would have purchased at the correct age.

SECTION VIII - BENEFIT SCHEDULE

Initial Maximum Benefit:	See Certificates
Reduced Maximum Benefit Amount:	See Certificates
Reduced Benefit Date:	First Renewal Date after age 70
Waiting Period:	30 Days
Percentage for Partial Benefits:	25%

100% of the applicable Maximum Benefit (Initial or Reduced) is payable for the following Specified Critical Illnesses

[Cancer]
Stroke
Kidney Failure
Heart Attack
Major Organ Transplant

PARTIAL BENEFITS

[CANCER]

Carcinoma in situ - When this Partial Benefit is paid, it will reduce the cancer benefit by 25%.

HEART ATTACK

Coronary Artery Bypass Surgery - When this Partial Benefit is paid, it will reduce the Heart Attack Benefit by 25%.

Maximum Health Screening Benefit Amount: [\$50] per insured Employee and Spouse per calendar year.

SECTION IX - OCCUPATIONAL CLASSIFICATIONS

[All Full-Time employees, who are actively at work, and have completed at least 6 months of continuous employment with the Participant.]

SECTION X - SCHEDULE OF PREMIUMS



120 ROYALL STREET ♦ CANTON, MASSACHUSETTS 02021 ♦ TEL. (800) 669-2668 ♦ FAX (781) 770-0521

CERTIFICATE OF INSURANCE FOR GROUP CRITICAL ILLNESS POLICY

**THIS CERTIFICATE PROVIDES BENEFITS FOR THE SPECIFIED DISEASES LISTED.
IT DOES NOT PROVIDE BENEFITS FOR ANY OTHER SICKNESS OR CONDITION.**

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

PLEASE READ YOUR CERTIFICATE CAREFULLY

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare.

CERTIFICATE INDEX

Eligibility, Effective Date and Termination	Section I
Premium Provisions.....	Section II
General Definitions / Benefit Definitions.....	Section III
Benefit Provisions.....	Section IV
Limitations and Exclusions.....	Section V
Claim Provisions.....	Section VI
General Provisions.....	Section VII

We certify that you are insured under the Specified Critical Illnesses Policy (herein called the Plan) issued to the Policyholder, subject to the definitions, exclusions and other provisions of the Plan against loss resulting from Specified Critical Illness. Certain provisions of the Plan are summarized in this Certificate. All provisions of the Plan, whether contained in your Certificate or not, apply to the insurance referred to by the Certificate.

The Effective Date of your Certificate is as shown in the Certificate Schedule if you are on that date actively at work for the Participant. If not, this Certificate will become effective on the next date you are actively at work as an eligible Employee. This Certificate will remain in effect for the period for which the premium has been paid. This Certificate may be continued for further periods as stated in the Plan.

This Certificate is issued in consideration of the payment in advance of the required premium and of your statements and representations in the application. This Certificate, on its Effective Date, automatically replaces any Certificate or Certificates previously issued to you under the Plan. "You" and "your" refer to the Employee or any other Insured under Family Coverage. "We", "us", and "our" refer to the Company. The Participant may add new Employees from time to time in accordance with the terms of the Plan. This Certificate, on its Effective Date, automatically replaces any Certificate or Certificates previously issued to you under the Plan.

NO RECOVERY FOR PRE-EXISTING CONDITIONS--READ CAREFULLY. No benefits will be provided during the first twelve months of this Certificate for conditions diagnosed within the 12-month period prior to the Effective Date shown in the Certificate Schedule.

SECTION I - ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

ELIGIBILITY

You as used in this Certificate, means a person insured under this Certificate who is:

1. an Employee of the Participant, or an eligible Spouse of the Employee;
2. under age 70;
3. engaged in full-time work; and
4. included in the class of Employees eligible for coverage as shown on the application.

EFFECTIVE DATE

The Effective Date of the Plan is shown on Page 1 of the Master Policy.

The Effective Date for you is as follows:

1. Your insurance will be effective on the date shown on the Certificate Schedule provided you are actively at work.
2. If you are not actively at work on the date coverage would otherwise become effective, the Effective Date of your coverage will be the date on which you are first thereafter actively at work.

The Effective Date for a Spouse or Dependent Child is the date shown on the Schedule Page subject to the following:

1. The date your insurance is effective for Dependents who are eligible on that date; for whom coverage is applied for and premium paid; and who are not hospital confined.
2. At 12:00 a.m. Standard Time, on the day a Dependent is no longer hospital confined if the Dependent was otherwise eligible for coverage on the date the your insurance became effective.
3. For a Dependent eligible on or first acquired after your Effective Date, the Effective Date will be:
 - a. For newborn children, the Effective Date is the moment of birth, but we must be given notice of the birth within 31 days for coverage to continue beyond 31 days (see Section III, Definitions, Insured).
 - b. For other than newborn children, the date we assign after approving the application for such coverage.

TERMINATION OF YOUR INSURANCE

Your insurance will terminate on the earliest of:

1. the date the Plan is terminated;
2. the date your employer is no longer a Participant;
3. on the 31st day after the premium due date if the required premium has not been paid;
4. on the date you ceases to meet the definition of an Employee as defined in the Plan; or
5. on the date you are no longer a member of the class eligible.

Insurance for insured spouse or Dependent Children will terminate the earliest of:

1. the date the Plan is terminated;
2. the date you are no longer insured under this Plan;
3. on the 31st day after the premium due date if the required premium has not been paid;

4. the premium due date following the date your spouse or child ceases to be a dependent;
5. the premium due date following the date we receive your written request to terminate coverage for your spouse and/or all Dependent Children.

Termination of the insurance on any Insured shall be without prejudice to an Insured's rights as regarding any claim arising prior thereto.

SECTION II - PREMIUM PROVISIONS

PREMIUM CALCULATIONS

Premiums payable on any premium due date for insurance will be calculated in accordance with the Schedule of Premiums. The rates shown in this Schedule can be changed annually. The Company will give the Participant written notice 31 days prior to the date any change in rates is to be effective.

PREMIUM PAYMENTS

The first premiums are due on the Effective Date of this Plan. After that, premiums are due on the first day of each month that the Plan remains in effect.

Aggregate premiums for this Plan are to be paid by the Participant to the Company our Home Office in Boston, Massachusetts. Payment of any premium will not keep the Plan in force beyond the due date of the next premium, except as set forth in the Grace Period.

GRACE PERIOD

The Plan has a 31-day Grace Period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the next 31 days. During the Grace Period, this Certificate will stay in force, unless the Participant has given the Company written notice of discontinuance of the Plan.

SECTION III - GENERAL DEFINITIONS / BENEFIT DEFINITIONS

Insured(s) -

1. If this is Individual coverage as shown in the Certificate Schedule, we insure you.
2. If this is coverage for your Spouse, we insure the Insured as shown on the Certificate Schedule.
3. Coverage for Dependent Children may be included in an attached Rider (if applicable). Coverage for Dependent Children is subject to the following:
 - a. Newborn Children of you and/or your insured spouse shall automatically be covered from birth provided that you notify us within thirty-one (31) days after the birth of the child. Foster children shall be eligible for coverage on the same basis upon placement in the foster home.
 - b. Children for which a decree of adoption has been entered by you or your spouse (or for whom adoption proceedings have been instituted by you or your spouse), shall be covered automatically from birth. A decree of adoption must be entered within one year from the date proceedings were instituted, unless extended by order of the court, and you or your spouse must continue to have custody pursuant to the decree of the court.
4. If any person who would otherwise be an Insured is specifically excluded from coverage by endorsement to this Certificate or by the application, then such person shall not be an Insured.
5. Any other additions to the Insured class must be added by endorsement after applying to the Company.

Successor Insured - If you die while covered under this Certificate, then your surviving spouse shall become the Insured if your spouse is an Insured. If there is no surviving spouse covered under this Certificate, then this Certificate shall terminate on the next premium due date.

Dependent Children - All of your children who are unmarried and less than twenty-five (25) years of age. However, if any Dependent Child is incapable of self-sustaining employment due to mental retardation or physical handicap and is Dependent on a parent(s) for support, such age of twenty-five (25) shall not apply. Proof of such incapacity and dependency must be furnished to the Company within thirty-one (31) days following such 25th birthday.

Pathologist means a doctor, other than yourself or a family member, who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A Pathologist also means an Osteopathic Pathologist who is certified by the Osteopathic Board of Pathology.

Treatment means consultation, care or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.

Doctor or Physician means any licensed practitioner of the healing arts acting within the scope of his license in treating an injury or illness. It doesn't include you or a family member.

Family Member means an Insured's spouse, son, daughter, mother, father, sister, or brother.

Illness means sickness or disease which first manifests while this Certificate is in force and after any applicable Waiting Period. Any loss due to illness must begin while this Certificate is in force.

Injury means bodily injury solely due to an accident. It includes all complications of and all injuries from the same accident. The accident must occur and any loss due to injury must begin while this Certificate is in force and after any applicable Waiting Period.

Specified Critical Illness means such illness shown in the Schedule and as defined in this Certificate.

Waiting Period means the number of days after the Effective Date before we will pay benefits for loss due to a Specified Critical Illness. We won't pay benefits for a Specified Critical Illness that begins during the Waiting Period.

Actively at Work- to be considered "actively at work", the Insured must perform for a full normal workday the regular duties of his employment at the regular place of business the Participant or at a location to which he may be required to travel to perform the regular duties of his employment.

Full-time Work means spending at least [30] hours per week performing your occupational duties.

You or "your" means the person named in the Certificate Schedule.

Participant means your employer who is a member of the Boston Mutual Life Insurance Trust.

Whenever a male pronoun is used, it includes the female unless the context clearly shows otherwise.

BENEFIT DEFINITIONS

Date of Diagnosis: The date of diagnosis is:

[**For Cancer and/or Carcinoma in Situ:** The day the tissue specimen, blood samples and/or titer(s) are taken on which the first diagnosis of Cancer or Carcinoma in Situ is based.]

For Heart Attack: The date that the death (infarction) of a portion of the heart muscle occurred based on the criteria listed under the Heart Attack definition.

For Stroke: The date a Stroke occurred based on documented neurological deficits and neuroimaging studies.

For End Stage Renal Failure: The date that your doctor or physician recommends that you begin renal dialysis.

Major Organ Transplant Surgery or Coronary Artery Bypass Surgery: The date the surgery occurs for covered Transplants or covered Coronary Artery Bypass Surgery.

[**Cancer** – means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of distant tissue. Cancer includes Leukemia. Excluded are Cancers such as:

1. Pre-malignant tumors or polyps;
2. Carcinoma in Situ (non-invasion);
3. Any skin cancers except melanomas;
4. Stage 1 Hodgkin's Disease and Stage A Prostate Cancer;
5. Basal cell carcinoma and squamous cell carcinoma of the skin; and
6. Melanoma that is diagnosed as Clark's Level I or II or Breslow less than .77mm.

Cancer is also defined as Cancer which meets the diagnosis criteria of malignancy established by the American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen.

Carcinoma in situ - Means Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

Cancer and/or Carcinoma in Situ must be diagnosed in one of two ways:

1. **Pathological Diagnosis** - A Pathological Diagnosis of Cancer or Carcinoma in Situ is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a Certified Pathologist whose diagnosis of malignancy is in keeping with the standards set up by the American Board of Pathology.
2. **Clinical Diagnosis** - A Clinical Diagnosis of Cancer or Carcinoma in Situ is based on the study of symptoms.

We will pay benefits for a Clinical Diagnosis only if:

- a. a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening; and
- b. there is medical evidence to support the diagnosis; and
- c. a doctor is treating you for Cancer and/or Carcinoma in Situ.]

Myocardial Infarction (Heart Attack) means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Heart Attack does not include any other disease or injury involving the cardiovascular system. Cardiac Arrest not caused by a Myocardial Infarction is not a Heart Attack. The diagnosis must include all of the following criteria:

1. New and serial Electrocardiographic (EKG) findings consistent with Myocardial Infraction; and

2. Elevation of cardiac enzymes above generally accepted laboratory levels of normal in case of creatine phosphokinase (CPK), a CPK-MB measurement must be used.
3. Confirmatory imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.
4. Chest Pain.

Coronary Artery Bypass Surgery means undergoing open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding procedures such as, but not limited to balloon angioplasty, laser relief, stints or other non-surgical procedures.

Major Organ Transplant means undergoing surgery as a recipient of a transplant of a human heart, lung, liver, kidney, or pancreas.

Stroke means apoplexy (due to rupture or acute occlusion of a cerebral artery), or a cerebral vascular accident or incident, which is first manifested on or after the policy date. Stroke does not include Transient Ischemic Attacks and attacks of Vertebrobasilar Ischemia. We will pay a benefit for Stroke which produces permanent clinical neurological sequela following an initial diagnosis made after any applicable Waiting Period. We must receive evidence of the permanent neurological damage provided from Computed Axial Tomography (CAT scan) or magnetic Resonance Imaging (MRI). **Stroke does not mean head injury, transient ischemic attack or chronic cerebrovascular insufficiency.**

Renal Failure (Kidney Failure) means the end stage renal failure presenting as chronic, irreversible failure of both of your kidneys to function. The Kidney Failure must necessitate regular renal dialysis, hemo-dialysis or peritoneal dialysis (at least weekly); or which results in kidney transplantation. Renal failure is covered, provided it is not caused by a traumatic event, including surgical traumas.

SECTION IV - BENEFITS

Specified Critical Illness Benefit

We will pay this benefit if an Insured is diagnosed with one of the Specified Critical Illnesses shown on the Certificate Schedule if:

1. The date of diagnosis is after the Waiting Period;
2. The date of diagnosis is while this Certificate and is in force; and
3. It is not excluded by name or specific description in this Certificate.

If the date of diagnosis of a Specified Critical Illness occurs during the Waiting Period, the Certificate may be returned for a full refund of premium.

The Certificate's Initial Maximum Benefit amount is shown in the Schedule. If the Schedule shows a Maximum Benefit Reduction Date, a Certificate's Maximum Benefit will be reduced to the Reduced Maximum Benefit Amount, also shown in the Schedule, on that date. Benefits will be based on the Maximum Benefit amount in effect when the loss begins. Any partial benefits paid will be deducted from the appropriate Specified Critical Illness.

Payment of benefits is subject to the following:

1. We will pay benefits for a Specified Critical Illness in the order the events occur.
2. No benefits are payable for each Specified Critical Illness after the first unless its date of diagnosis is separated from the prior Specified Critical Illness by at least 6 months.

3. Once benefits have been paid for a Specified Critical Illness, no additional benefits are payable for that same Specified Critical Illness unless the dates of diagnosis are separated by at least 12 months (12 months treatment free for cancer).

[Portability Privilege]

When your coverage would otherwise terminate under this Plan because you end employment with the Employer, you may elect to keep your certificate enforce. You must have been continuously insured for at least six months under this Plan and/or the prior Plan just before the date your employment terminated. The coverage you may continue is that which you had on the date your employment terminated, including Dependent coverage then in effect.

1. Coverage may not be continued for any of the following reasons:
 - a. you failed to pay any required premium;
 - b. you have attained age 70;
 - c. the Group Policy terminates.
2. To keep your insurance in force you must:
 - a. make written Application to the Company within 31 days after the date your insurance would otherwise terminate;
 - b. pay the required premium to the Company no later than 31 days after the date your insurance would otherwise terminate; and
3. Insurance will cease on the earliest of these dates:
 - a. the date you failed to pay any required premium;
 - b. the date the Group Policy is terminated.

If you qualify for this Portability Privilege as described, then the same benefits, Plan provisions, and premium rate as shown in your Certificate as previously issued will apply.]

[Health Screening Benefit (Calendar Year Limit)]

We will pay this benefit for the following Health Screening Tests performed after the Waiting Period and while this Certificate is in force. We will pay the amount shown in the Certificate Schedule for the following Health Screening Tests. This benefit is payable once per Calendar Year up to the Maximum Benefit amount shown in your Certificate Schedule. Payment of this benefit will not reduce the face amount of the Certificate.

Health Screening Test is defined as:

1. Stress test on a bicycle or treadmill,
2. Fasting blood glucose test,
3. Blood test for triglycerides,
4. Serum cholesterol test to determine level of HDL and LDL,
5. Bone marrow testing,
6. Breast ultrasound,
7. CA 15-3 (blood test for breast cancer),
8. CA 125 (blood test for ovarian cancer),
9. CEA (blood test for colon cancer),
10. Chest X-ray,
11. Colonoscopy,
12. Flexible sigmoidoscopy,
13. Hemocult stool analysis,

14. Mammography,
15. Pap smear,
16. PSA (blood test for prostate cancer),
17. Serum Protein Electrophoresis (blood test for myeloma),
18. Thermography.

There is no limit to the number of years you can receive benefits for Health Screening Tests, as long as this Certificate is in force.

We will pay this benefit regardless of the results of the test.]

SECTION V - LIMITATIONS AND EXCLUSIONS

This Certificate contains a 30-day "Waiting Period". This means no benefits are payable for any Insured who has been diagnosed before coverage has been in force 30 days from the "Effective Date" shown in the Certificate Schedule. If an Insured is first diagnosed during the "Waiting Period", benefits for treatment of that Critical Illness or Specified Procedure will apply only to loss commencing after 12 months from the "Effective Date" of their coverage; or, at your option, you may elect to void the Certificate from the beginning and receive a full refund of premium.

PRE-EXISTING CONDITIONS LIMITATION

"Pre-existing Condition" means a sickness or physical condition which, within the 12-month period prior to the Effective Date of an Insured's coverage that resulted medical advice or treatment.

We will not pay benefits for any condition or illness starting within 12 months of the Effective Date of an Insured which is caused by, contributed to, or resulting from a Pre-existing Condition.

A claim for benefits for loss starting after 12 months from the Effective Date of an Insured will not be reduced or denied on the grounds that it is caused by a Pre-existing Condition.

A condition will no longer be considered Pre-existing at the end of 12 consecutive months starting and ending after the Effective Date of an Insured's coverage.

EXCLUSIONS

We won't pay for loss due to:

1. Intentionally self inflicted injury or action.
2. Suicide or attempted suicide while sane or insane.
3. Illegal activities or participation in an illegal occupation.
4. War - declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence.
5. Substance Abuse.

SECTION VI - CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within sixty (60) days after a covered loss starts, or as soon as reasonably possible. The notice can be given to the Company at our Administrative Office at P.O. Box 1807, Columbia, South Carolina 29202. Notice should include the name of the Insured and the Certificate number.

Claim Forms: When we receive a notice of claim, we will send the claimant forms for filing proof of loss. If the forms are not given within 15 working days, proof of loss requirements can be met by giving us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss Section.

Proof of Loss: Written Proof of Loss must be furnished to the Company at our Administrative Office at P.O. Box 1807, Columbia, South Carolina 29202 within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than one year from the time proof is otherwise required.

Notice Of Our Claim Decisions - We will send you written notice of our claim decision within 30 days after we receive due proof of your loss. If there are special circumstances that require more time (such as the need to hold a hearing), we will send you a written notice within this timeframe that an additional 30 days is needed. If more time is still needed to make a claim determination, we will send you written notice during this initial 30 day extension stating the special circumstances that require an additional 30 days. You will have 45 days to provide any additional information requested.

If your claim is urgent, we will notify you of our decision within 72 hours. If we need more information, we will let you know within 24 hours of your claim. At that time we will tell you what additional information is needed to process your claim. You will have 48 hours to provide any additional information requested. We will notify you of our decision within 48 hours after we receive the requested information. Our response to an urgent care claim may be oral; if it is, we will confirm our decision in writing.

We will treat your claim as urgent if a delay in processing your claim could seriously jeopardize your life, health, or ability to regain maximum function, or if in the opinion of the treating physician, a delay would subject you to severe pain that cannot be managed without the care or treatment that is the subject of your claim.

If the claim is wholly or partly denied, our notice will include:

1. Reasons for such denial;
2. Reference to specific policy provisions, rules or guidelines on which the denial was based;
3. A description of the additional information needed to support your claim;
4. Information concerning your right to request that we review our decision; and
5. A description of our review procedures, time limits and notice of your right to bring civil action.

Review Of Denied Claims - For non-urgent claims this request must be in writing and must be received by us no more than 180 days after you receive notice of our claim decision. A request for a review of an urgent claim may be made over the phone. As part of this review, you may:

1. Send us written comments;
2. Review any non-privileged information relating to your claim; or
3. Provide us with other information or proof in support of your claim.

We will review your claim promptly after receiving your request. We will advise you of the results of our review within 60 days after we receive your request, or within 120 days if there are special circumstances that require more time (such as the need to hold a hearing). Our decision will be in writing and will include reference to specific policy provisions, rules or guidelines on which the decision was based, and notice of your right to bring a civil action.

If your appeal arises from our denial of an urgent claim, we will consider your appeal and notify you of our decision within 72 hours.

Time of Payment of Claims: Benefits payable under this Certificate will be paid immediately upon receipt of acceptable Proof of Loss.

Payment of Claims: All Benefits will be payable to you unless assigned by you or by operation of law. Any accrued benefit unpaid at your death may be paid to your estate.

Conformity with State Statutes: Any Provision of this Certificate which, on its "Effective Date", is in conflict with the statutes of the state in which it was issued is hereby amended to conform to the minimum requirements of such statutes.

Additional Coverage with the Company: We will only pay benefits for covered Specified Critical Illness under one Specified Critical Illness Certificate if you are covered by more than one of our Specified Critical Illness Certificates. You may choose which Certificate you wish to keep in force by sending us written notice of your choice. We will return the premiums you paid for any of our other Specified Critical Illness Certificate during the period you had more than one Certificate in force.

SECTION VII - GENERAL PROVISIONS

Questions or Comments: We want to hear from you. If you have any questions about this policy, its benefits, the filing of claims, a complaint or a compliment, please call us at the toll free number listed (or write to us) on the front of this Certificate. Thank you for your loyal patronage.

Entire Contract, Changes: The Master Policy together with the application, endorsements, benefit agreements, certificates and riders, if any, is the Entire Contract of Insurance. No change in this Certificate shall be valid until approved in writing by an executive officer of the Company. Any change must be noted on or attached hereto. No agent may change this Certificate or waive any of its provisions. Any rider, endorsement or application that modifies, limits or excludes coverage under this Certificate must be signed by you, the insured, to be valid.

Physical Examination and Autopsy: We, at our expense, have the right to have you examined as often as reasonable necessary while a claim is pending. In the case of death, we may also have any autopsy done unless prohibited by law.

Legal Action: No legal action may be brought to recover on this Certificate within 60 days after written proof of loss has been given as required by this Certificate. No such action may be brought after 3 years from the time written proof of loss is required to be given.

Time Limit on Certain Defenses: (1) After two years from the Effective Date of coverage, no misstatements, except fraudulent misstatements, made by the applicant in the application shall be used to void the coverage or to deny a claim for loss incurred commencing after the expiration of such two-year period (2) No claim for loss incurred commencing after two years from the Effective Date of coverage shall be reduced or denied on the grounds that a disease or physical condition, not excluded from coverage by name or specific description, had existed prior to such Effective Date.

Misstatement of Age: If an age has been misstated on the application, the benefits will be those the premium paid would have purchased at the correct age.

SECTION VIII – CERTIFICATE SCHEDULE

POLICYHOLDERS NAME: [ABC Corp]

POLICYHOLDERS NUMBER: [XXXX]

SCHEDULE OF BENEFITS

INITIAL MAXIMUM BENEFIT AMOUNT: [\$40,000]

SCHEDULE OF PREMIUMS

MONTHLY PREMIUM AMOUNT: [XX.XX]

REDUCED MAXIMUM BENEFIT AMOUNT: [\$20,000]

REDUCED BENEFIT DATE: First Renewal Date after age 70

WAITING PERIOD: 30 Days

**PERCENTAGE FOR
PARTIAL BENEFITS:** 25%

100% of the applicable Maximum Benefit (Initial or Reduced) is payable for the following Specified Critical Illnesses

[Cancer]
Stroke
Kidney Failure
Heart Attack
Major Organ Transplant

PARTIAL BENEFITS

[CANCER]

Carcinoma in situ - When this Partial Benefit is paid, it will reduce the cancer benefit by 25%.

HEART ATTACK

Coronary Artery Bypass Surgery - When this Partial Benefit is paid, it will reduce the Heart Attack Benefit by 25%.

Maximum Health Screening Benefit Amount: [\$50] per insured Employee and Spouse per calendar year.

[DEPENDENT CHILDREN COVERAGE]

Initial Maximum Benefit Amount: [\$10,000]

[ACTIVITY OF DAILY LIVING]

MONTHLY PREMIUM AMOUNT:

ADL Benefit
Maximum Benefit Period
Payments

[\$ xxxxx or 4x the base plan Initial Critical Illness Benefit]
[60 months]
[\$xxxx/month]

[The ADL benefit payable is calculated by multiplying the Initial Critical Illness benefit in your certificate and dividing by the Benefit Period above.]

[Example:

Base CI Certificate: \$15,000
ADL Benefit: \$60,000
Benefit Period: 60 Months
Benefit payments: \$1,000 / Month]

SKILLED NURSING FACILITY BENEFIT

Skilled Nursing Facility Benefit
Maximum Benefit Period

[\$xxxx/month]
[60 months]

INSURED: [John Doe]

CERTIFICATE NUMBER: [XXXX]

CERTIFICATE EFFECTIVE DATE: [06/01/07]

FIRST RENEWAL DATE: [07/01/08]

[ACTIVITIES OF DAILY LIVING RIDER EFFECTIVE DATE: [06/01/07]]



120 ROYALL STREET ♦ CANTON, MASSACHUSETTS 02021 ♦ TEL. (800) 669-2668 ♦ FAX (781) 770-0521

**DEPENDENT CHILDREN BENEFIT RIDER
TO CERTIFICATE OF INSURANCE
FOR CRITICAL ILLNESS**

This Rider is a part of the Certificate to which it is attached. We have issued this Rider to you. We relied on the application you made. Unless amended by this Rider, Certificate Definitions, other Provisions and terms apply to this Rider.

Effective Date - If issued at the same time as the Certificate, this Rider becomes effective when the Certificate becomes effective. If issued after the Certificate becomes effective, this Rider will have a later Effective Date, which will be shown in the Certificate Schedule. The insurance of a Dependent will become effective on the Rider date if such person is active on that date. Otherwise, the Effective Date will be deferred until the day following the date he becomes active.

DEFINITIONS

When the terms below are used in this Rider, the following definitions will apply:

YOU, YOUR	Means the person named in the Certificate Schedule.
CHILDREN	<p>Means your natural Children, step-Children, legally adopted Children or Children placed for adoption, who:</p> <ul style="list-style-type: none">• are unmarried;• are chiefly dependent on you or your Spouse for support; and• are younger than age 25. <p>"Children" also includes Dependent Children, regardless of age, who:</p> <ul style="list-style-type: none">• are mentally or physically handicapped;• became or become handicapped prior to age 25; and• cannot support themselves because of their handicap. <p>If your Children are covered under this Rider, your Children born after the Effective Date of this Rider will also be covered from the moment of live birth. No notice or additional premium is required.</p>
DEPENDENT	Means your Child or Children, named in the application for this Rider for whom a premium is paid.
ACTIVE	"Active" as used refers to a Dependent who is not confined in a hospital and who is able to carry on regular activities customary of a person in good health of the same age and sex.

TREATMENT Means consultation, care or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.

BENEFITS

If a Dependent Child contracts a Specified Critical Illness after any applicable Waiting Period and while this Rider is in force, we will provide the benefits contained in the Certificate under the Benefits Section. The appropriate benefit amounts we will pay for the Dependent are shown in the Certificate Schedule.

LIMITATIONS AND EXCLUSIONS

This Rider contains a 30-day "Waiting Period". This means no benefits are payable for any covered Dependent who has been diagnosed before coverage has been in force 30 days from his "Effective Date." If a Dependent is first diagnosed during the "waiting period", benefits for treatment of that Critical Illness or Specified Procedure will apply only to loss commencing after 12 months from the "Effective Date" of their coverage; or, at your option, you may elect to void their coverage from the beginning and receive a full refund of any applicable premium.

LIMITATIONS

PRE-EXISTING CONDITIONS

"Pre-existing Condition" means a sickness or physical condition which, within the 12-month period prior to a Dependent's Effective Date resulted in the Dependent receiving medical advice or treatment.

We will not pay benefits for any condition or illness starting within 12 months of a Dependent's Effective Date which is caused by, contributed to, or resulting from a Pre-existing Condition.

A claim for benefits for loss starting after 12 months from a Dependent's Effective Date will not be reduced or denied on the grounds that it is caused by a Pre-existing Condition.

A condition will no longer be considered Pre-existing at the end of 12 consecutive months starting and ending after a Dependent's Effective Date.

EXCLUSIONS

We won't pay for loss due to:

1. Intentionally self inflicted injury or action.
2. Suicide or attempted suicide while sane or insane.
3. Illegal activities or participation in an illegal occupation.
4. War - declared or undeclared or military conflicts, participation in an insurrection or riot, civil commotion or state of belligerence.
5. Substance Abuse.

GENERAL PROVISIONS

If your Dependent Child's coverage is terminated because of marriage or attainment of the limiting age, we will still pay benefits for any covered condition that was diagnosed while the Dependent was covered under this Rider.

TIME LIMIT ON CERTAIN DEFENSES


After this Rider has been in force for a period of two years it shall become incontestable as to the statements contained in the Application.

CONTRACT

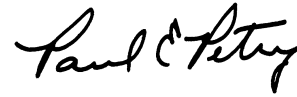
This Rider is part of the Certificate, and will terminate when the Certificate terminates, or when premiums are no longer paid for this Rider.

This Rider is subject to all of the terms of the Certificate to which it is attached unless any such terms are inconsistent with the terms of this Rider.

Signed by the Company at our Home Office.



Secretary



President



ACTIVITIES OF DAILY LIVING / SKILLED NURSING RIDER TO CERTIFICATE OF INSURANCE FOR CRITICAL ILLNESS

This rider is a part of the policy/certificate to which it is attached. We have issued this rider to you because (1) you paid the additional premium for this rider; and (2) we relied on the application you made. Unless amended by this rider, Policy/Certificate Definitions and other terms and provisions apply to this rider.

Effective Date - If issued at the same time as the certificate, this rider becomes effective when the certificate becomes effective. If issued after the certificate becomes effective, this rider will have a later Effective Date, which will be shown in the Certificate Schedule.

ELIGIBILITY

You are eligible for coverage under this rider if you are:

1. an Employee of the Participant;
2. [under age [59]; and]
3. engaged in full-time work; and
4. included in the class of Employees eligible for coverage shown on the application.

EXTENDED BENEFITS FOR ACTIVITIES OF DAILY LIVING AND SKILLED NURSING FACILITY

The following benefits are payable beginning on and after your 65th birthday. [This rider terminates when you reach age 80.]

Activities of Daily Living Benefit

We will pay the Monthly Benefit Amount shown on your Certificate Schedule page in the event you cannot perform 2 or more of the Activities of Daily Living. Payment of this benefit will begin when we receive satisfactory proof, from a United States licensed physician, that you are unable to perform 2 or more of the Activities of Daily Living.

The ADL benefit is an extension of the Critical Illness benefits payable to you under your Critical Illness Certificate.

This benefit is payable as long as you are unable to perform 2 or more of the Activities of Daily Living for a benefit period of up to [60 months]. **The Diagnosis must indicate that the condition is expected to be permanent. You must continue to be under the regular and appropriate care of a Physician.**

This benefit will **not** be paid concurrently with other benefits you may be receiving under your Certificate. This benefit is **not** payable in addition to the Skilled Nursing Facility Benefit. Activities of Daily Living that you are not able to perform prior to the effective date of your coverage will not be covered.

Skilled Nursing Facility Benefit

If you are confined to a Skilled Nursing Facility [because you cannot perform 2 or more of the Activities of Daily Living], we will pay the daily Skilled Nursing Facility Benefit monthly for the maximum benefit period shown on your Certificate Schedule.

This benefit is **not** payable in addition to the Activities of Daily Living Benefit or for confinement in a Skilled Nursing Facility outside the United States. Confinement must be within the territorial limits of the United States.

DEFINITIONS

Activities Of Daily Living (ADL's) means:

1. **bathing** – the ability to wash oneself in either a tub or shower, or by sponge bath; including the tasks of getting into and out of the tub or shower with or without the assistance of equipment;
2. **dressing** – the ability to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;
3. **toileting** – the ability to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene with or without the assistance of equipment;
4. **transferring** – the ability to move in and out of bed, chair or wheelchair with or without the assistance of equipment; mobility, the ability to walk or wheel on a level surface from one room to another with or without the assistance of equipment;
5. **eating** – the ability to get nourishment into the body by any means once it has been prepared and made available to one with or without the assistance of equipment; and
6. **continence** – the ability to voluntarily maintain control of bowel and/or bladder function or in the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

Skilled Nursing Facility means a facility which:

1. is licensed and operated as a Skilled Nursing Facility according to the law of the jurisdiction in which it is located;
2. provides skilled nursing care under the supervision of a physician;
3. provides continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (RN); and
4. maintains a daily medical record of each patient.

You means the person shown on your Certificate Schedule as the Insured.

GENERAL PROVISIONS

This rider is part of your Critical Illness certificate and will terminate when that certificate terminates, [at attained age 80,] or when premiums are no longer paid for this rider.

The premium for this rider is shown in your Certificate Schedule. [Premiums for this rider are payable for the number of years shown in your Certificate Schedule or until the Rider terminates.]


This rider is subject to all of the terms of the Critical Illness Certificate to which it is attached.

These changes will not affect your certificate, or any prior riders, except as stated above.

Signed for the Company at its Home Office.



Secretary



President



STRIKE WAIVER

The Policy or Certificate to which this rider is attached is hereby amended by adding the following provision:

TEMPORARILY NOT WORKING: We will continue Your coverage if we receive written notice that You are on Strike. Coverage will be continued for [three (3)] months following the last day of the month in which You are not engaged in full-time work due to a Strike. During the Strike, we will not require payment of premiums. If the Strike continues beyond the stated [three (3)] month period, you will be required to resume paying premiums for your certificate and any riders, including this rider, for coverage to remain in force.

Strike means a lawful primary strike authorized as provided by the union's constitution and by-law.

This rider is subject to all of the provisions of the Policy or Certificate as long as this rider does not amend them. This rider will terminate on the same date as the Policy or Certificate to which it is attached.

Signed for the Company at its Home Office.

A handwritten signature in cursive script, reading "Walter J. Gordon".

Secretary

A handwritten signature in cursive script, reading "Paul C. Petry".

President



120 ROYALL STREET
♦ CANTON, MASSACHUSETTS 02021
♦ TEL. (800) 669-2668
♦ FAX (781) 770-0521

FOR HOME OFFICE USE ONLY		
PLAN	PLAN CODE	ID NUMBER
Critical Illness		
Endorsement:		
EFFECTIVE DATE:		

Employee Name/Owner (First, MI, Last)		S.S.N./ ID Number		Gender	Date of Birth
Street Address		City		State	Zip
Employer		Job Class	Location		Date of Hire
Hours Worked	Daytime Phone No. ()	Beneficiary Name / Relationship (estate unless designated otherwise)			
Spouse's Name (if coverage is requested)		Gender	Spouse Date of Birth		

	Employee	Spouse
Are you actively at work?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Are you now hospitalized or unable to perform your normal duties and activities?		<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you used tobacco products in the last 12 months?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

CRITICAL ILLNESS	<input type="checkbox"/> Employee	<input type="checkbox"/> [Employee & Spouse]	[Section 125: <input type="checkbox"/> Yes <input type="checkbox"/> No]
Employee Face Amount: \$	Employee Cost per pay period: \$		<input type="checkbox"/> ADL Rider
Spouse Face Amount: \$	Spouse Cost per pay period: \$		<input type="checkbox"/> ADL Rider

		Employee	Spouse
1	Have you ever been treated for or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC) or ever tested positive for antigens or antibodies to an "AIDS" virus?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2	In the last 7 years have you been treated for or diagnosed with cancer or any malignancy, which includes carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or malignant tumor? Cancer does not include basal cell or squamous cell carcinoma.	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3	Have you ever been treated for a) a stroke, a heart attack, a heart condition, heart trouble, or any abnormality of the heart (including artery disease), diabetes, or any liver disorder; b) kidney (renal) failure or end stage kidney (renal) disease; c) organ transplant; d) emphysema or e) now taking 3 or more medications for high blood pressure?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

To the best of my knowledge and belief, the answers to the questions on this application are true and complete. They are offered to The Company as the basis for any insurance issued.

• Does this coverage replace or change any existing insurance? ☐ YES ☐ NO

• If "Yes," provide carrier and policy number: _____

CERTIFICATION: I have read the completed application and I realize any false statement or misrepresentation in the application may result in loss of coverage under the certificate. I understand that no insurance will be in effect until my application is approved and the necessary premium is paid.

Coverage will not become effective unless you are actively at work on the date of the enrollment and the effective date of coverage.

I understand and agree that the coverage that I am applying for may have a pre-existing condition exclusion.

I authorize my employer to deduct the appropriate dollar amount from my earnings and to deduct and pay The Company the premium required thereafter each pay period for my insurance.

Deduction start date _____

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Date _____ Signature of Applicant _____

Date _____ Signature of Agent _____ State of Enrollment _____

BM-2006-CI

Underwritten by:



Boston Mutual Life Insurance, 120 Royall St, Canton, MA 02021					
Employee Name/Owner (First, MI, Last)			S.S.N./ ID Number	Gender	Date of Birth
Street Address			City	State	Zip
Employer		Occupation	Location (if required)		Date of Hire
Hours Worked	Daytime Phone No. ()	Beneficiary Name / Relationship (estate unless designated otherwise)			
Spouse's Name (if coverage is requested)			Gender	Spouse Date of Birth	
			Employee	Spouse	
Are you actively at work?			<input type="checkbox"/> YES <input type="checkbox"/> NO		
Are you now hospitalized or unable to perform your normal duties and activities?					<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you or your spouse used tobacco products in the last 12 months?			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
CRITICAL ILLNESS with ADL Rider Yes ____ No ____ <input type="checkbox"/> Employee <input type="checkbox"/> [Employee & Spouse]					
Employee Face Amount: \$ _____		Employee weekly premium: \$ _____			
Spouse Face Amount: \$ _____		Spouse weekly premium: \$ _____			
		Total weekly premium: \$ _____			
			Employee	Spouse	
1	Have you ever been treated for or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC) or ever tested positive for antigens or antibodies to an "AIDS" virus?			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	
2	In the last 7 years have you been treated for or diagnosed with cancer or any malignancy, which includes carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or malignant tumor? Cancer does not include basal cell or squamous cell carcinoma.			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	
3	Have you ever been treated for a) a stroke, a heart attack, a heart condition, heart trouble, or any abnormality of the heart (including artery disease), diabetes, or any liver disorder; b) kidney (renal) failure or end stage kidney (renal) disease; c) organ transplant; d) emphysema or e) now taking 3 or more medications for high blood pressure?			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	
Special Requests: _____ To the best of my knowledge and belief, the answers to the questions on this application are true and complete. They are offered to The Company as the basis for any insurance issued. CERTIFICATION: I have read the completed application and I realize any false statement or misrepresentation in the application may result in loss of coverage under the certificate. I understand that no insurance will be in effect until my application is approved and the necessary premium is paid. Coverage will not become effective unless you are actively at work on the date of the enrollment and the effective date of coverage. I understand and agree that the coverage that I am applying for may have a pre-existing condition exclusion. I authorize my employer to deduct the appropriate dollar amount from my earnings and to deduct and pay The Company the premium required thereafter each pay period for my insurance. Deduction start date _____ Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. Date _____ Signature of Applicant _____ Date _____ Signature of Agent _____ Agent NPN # _____ State of Enrollment _____					

Boston Mutual Life Insurance, 120 Royall St, Canton, MA 02021					
Employee Name/Owner (First, MI, Last)			S.S.N./ ID Number	Gender	Date of Birth
Street Address			City	State	Zip
Employer		Occupation	Location (if required)		Date of Hire
Hours Worked	Daytime Phone No. ()	Beneficiary Name / Relationship (estate unless designated otherwise)			
Spouse's Name (if coverage is requested)			Gender	Spouse Date of Birth	
			Employee	Spouse	
Are you actively at work?			<input type="checkbox"/> YES <input type="checkbox"/> NO		
Has your spouse been hospitalized or treated at a medical facility on an in or out patient basis within the past six months?					<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you or your spouse used tobacco products in the last 12 months?			<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
CRITICAL ILLNESS with ADL Rider Yes ___ No ___ <input type="checkbox"/> Employee <input type="checkbox"/> [Employee & Spouse]					
Employee Face Amount: \$ _____		Employee weekly premium: \$ _____			
Spouse Face Amount: \$ _____		Spouse weekly premium: \$ _____			
		Total weekly premium: \$ _____			
			Employee	Spouse	
1	Have you ever been treated for or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC) or ever tested positive for antigens or antibodies to an "AIDS" virus?			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2	In the last 7 years have you been treated for or diagnosed with cancer or any malignancy, which includes carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or malignant tumor? Cancer does not include basal cell or squamous cell carcinoma.			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3	Have you ever been treated for a) a stroke, a heart attack, a heart condition, heart trouble, or any abnormality of the heart (including artery disease), diabetes, or any liver disorder; b) kidney (renal) failure or end stage kidney (renal) disease; c) organ transplant; d) emphysema or e) now taking 3 or more medications for high blood pressure?			<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Special Requests: _____					
To the best of my knowledge and belief, the answers to the questions on this application are true and complete. They are offered to The Company as the basis for any insurance issued.					
CERTIFICATION: I have read the completed application and I realize any false statement or misrepresentation in the application may result in loss of coverage under the certificate. I understand that no insurance will be in effect until my application is approved and the necessary premium is paid. Coverage will not become effective unless you are actively at work on the date of the enrollment and the effective date of coverage. I understand and agree that the coverage that I am applying for may have a pre-existing condition exclusion. I authorize my employer to deduct the appropriate dollar amount from my earnings and to deduct and pay The Company the premium required thereafter each pay period for my insurance. Deduction start date _____					
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.					
Date _____ Signature of Applicant _____					
Date _____ Signature of Agent _____ Agent NPN # _____ State of Enrollment _____					

<i>SERFF Tracking Number:</i>	<i>CAIC-125785270</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Boston Mutual Life Ins Co</i>	<i>State Tracking Number:</i>	<i>40021</i>
<i>Company Tracking Number:</i>	<i>5093</i>		
<i>TOI:</i>	<i>H07G Group Health - Specified Disease - Limited Benefit</i>	<i>Sub-TOI:</i>	<i>H07G.001 Critical Illness</i>
<i>Product Name:</i>	<i>AR BM Critical Illness</i>		
<i>Project Name/Number:</i>	<i>AR BM Critical Illness/5093</i>		

Rate Information

Rate data does NOT apply to filing.

<i>SERFF Tracking Number:</i>	<i>CAIC-125785270</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Boston Mutual Life Ins Co</i>	<i>State Tracking Number:</i>	<i>40021</i>
<i>Company Tracking Number:</i>	<i>5093</i>		
<i>TOI:</i>	<i>H07G Group Health - Specified Disease - Limited Benefit</i>	<i>Sub-TOI:</i>	<i>H07G.001 Critical Illness</i>
<i>Product Name:</i>	<i>AR BM Critical Illness</i>		
<i>Project Name/Number:</i>	<i>AR BM Critical Illness/5093</i>		

Supporting Document Schedules

Satisfied -Name:	Certification/Notice	Review Status:	Approved-Closed	08/27/2008
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Comments:

The forms are being filed for informational purposes only. These forms will be issued through an out of state trust, situated in Rhode Island. The forms were approved in the state of Rhode Island on 11/20/2007.

We called ARDOI and they told us there are no filing fees for informational filings.

Attachment:

CI Readability.pdf

Bypassed -Name:	Application	Review Status:	Approved-Closed	08/27/2008
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Bypass Reason: N/A

Comments:

Satisfied -Name:	Cover Letter & Authorization Letter	Review Status:	Approved-Closed	08/27/2008
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Comments:

Attachments:

Information only Submission Letter.pdf

AuthLetter.pdf



120 ROYALL STREET ♦ CANTON, MASSACHUSETTS 02021 ♦ TEL. (800) 669-2668 ♦ FAX (781) 770-0521

READABILITY CERTIFICATION

I, James J. Hennessy, hereby certify that the following form has the following readability score as calculated by the Flesch Reading Ease Test:

<u>Form</u>	<u>Readability Score</u>
BMT2100-MP	46
BMT2100-CI	44
BMT2100-DCR RI	42
BMTCIADL	43
BMSW	57
BM-2006-CI	44.3
BM-CI-707 STD	44.6
BM-CI-SPS-GI-707 STD	45.4

James J. Hennessy, AIRC, ACP, CCP
Authorized Consultant
Vice President, CAIC

August 21, 2008

Date



120 ROYALL STREET ♦ CANTON, MASSACHUSETTS 02021 ♦ TEL. (800) 669-2668 ♦ FAX (781) 770-0521

August 21, 2008

Mr. Harris Shearer
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

Re: BOSTON MUTUAL LIFE INSURANCE COMPANY
NAIC: 61476 Group # 0581 FEIN 04-1106240

BMT2100-MP	Master Policy
BMT2100-CI	Certificate
BMT2100-DCR RI	Dependent Rider
BMTCIADL	Activities of Daily Living/Skilled Nursing Rider
BMSW	Strike Waiver
BM-2006-CI	Enrollment Application
BM-CI-707 STD	Enrollment Application
BM-CI-SPS-GI-707	Enrollment Application

Dear Mr. Shearer:

The above captioned forms are being filed for informational purposes only. These forms will be issued through an out of state trust, situated in Rhode Island. The forms were approved in the state of Rhode Island on 11/20/2007.

The forms contained in this filing represents Boston Mutual Life's Critical Illness Insurance which offers lump sum benefits to covered individuals upon diagnosis of a covered critical illness. This Plan of insurance will be marketed by Boston Mutual Life Insurance Company to employees of an employer on a voluntary, payroll deduction basis. This policy offers coverage to employees and their dependants.

Boston Mutual Life Insurance Company has retained Continental American Insurance Company to submit this filing on their behalf. A letter of authorization from Boston Mutual is enclosed.

Thank you for your consideration in this matter. Please contact Cindy Lama at 888-730-2244, ext: 4333 or at CompanyCompliance@caicworksite.com if you need any additional information.

Sincerely,

James J. Hennessy, AIRC, ACP, CCP
Authorized Consultant
Vice President, CAIC
/clc



120 ROYALL STREET ♦ CANTON, MASSACHUSETTS 02021 ♦ TEL. (800) 669-2668 ♦ FAX (781) 770-0521

August 21, 2008

To Whom It May Concern:

The firm of Continental American Insurance Company located at 2801 Devine Street, Columbia, South Carolina, is hereby authorized to submit forms for approval to the Department of Insurance on behalf of Boston Mutual Life Insurance Company. Changes to the forms, as may be necessary to gain approval, are included in this authorization.

Sincerely,

Richard Miller
Director, Contracts & Compliance
Boston Mutual Life Insurance Co.
Phone: 781 770 0423
Fax: 781 770 0521